REVOCATION OF AUTHORIZATION TO DISCLOSE INFORMATION

ND DEPARTMENT OF HUMAN SERVICES

SFN 91 (Rev. 4/2005)

Clear Fields

Client Name	Client Number	Date of Birth

I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

The Department of Human Services and its employees are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

I do hereby revoke my Authorization to Disclose Information by the _____

(Name of Unit)

to _____ .

Client's Signature	Date	Time

Parent/Guardian or Custodian Signature and relationship (if applicable)	Date	Time